Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: A Better Living	**CHAPTER 100.1**
Address: **83 Kilani Avenue, Wahiawa, Hawaii 96786**	**Inspection Date: November 1, 2019 Annual**

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident. **FINDINGS** Resident #1-Tylenol 325 mg 2 tabs Q4H PRN ordered on 1/29/19, reason for PRN not specified in MD order, medication label, and medication administration record.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Order from PCP of Tylenol 325 mg ii tabs q 4° prn for fever/pain was obtained	11/21/19

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident. **FINDINGS** Resident #1-Tylenol 325 mg 2 tabs Q4H PRN ordered on 1/29/19, reason for PRN not specified in MD order, medication label, and medication administration record.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** MD should always specify the reason for the PRN in MD's order and should reflect on medicine label and MAR. "Reminder" is included on ADH Check List Form (ARCH JR32) and placed in front of chart.	11/21/19

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident. **FINDINGS** Resident #1-Colace 100mg 1 gel capsule QD PRN ordered on 1/29/19, reason for PRN not specified in MD order, and medication administration record.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** Order from PCP was obtained. 11/21/19 Colace 100g 1 tab q d prn for constipation	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (f) Medications made available to residents shall be recorded on a flowsheet. The flowsheet shall contain the resident's name, name of the medication, frequency, time, date and by whom the medication was made available to the resident. **FINDINGS** Resident #1-Colace 100mg 1 gel capsule QD PRN ordered on 1/29/19, reason for PRN not specified in MD order, and medication administration record.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** MD should always specify the reason for PRN in MD's Order and should reflect on medicine label + MAR. REMINDER was included in ADM check list Form (ARCHIVE) and placed in front of Chart	11/21/19

621-7635

Maluhia Geriatric Physician Services
1027 Hala Drive
Honolulu, HI 96817
Phone: (808) 832-6132 Fax: (808) 832-1932

Name: Doris Yamaguchi

Address: _____ DOB: 2/7/1931

Melanie Kelly, M.D. 1027 Hala Drive, Honolulu, HI 96817 Phone: 808 832-6132, Fax: 808 832-1932	
Date Ordered	ORDERS
	Tylenol 325 mg 2 tablet q4° prn for pain & fever
	Colace 100 mg 1 tablet qd prn for constipation
Signature of Nurse Receiving Order	Signature of Physician MKelly MS Date 11/21/19 DEA NO:

3/29/2017

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-87 Personal care services. (e) The primary care giver with the assistance of the case manager shall provide training to all substitute care givers and ensure that all services and interventions indicated in the expanded ARCH resident's care plan are provided to expanded ARCH residents by the substitute care giver. **FINDINGS** No documented case manager training for secondary care giver #2 and secondary care giver #4.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY** CM rendered training for secondary care giver #2 & #4 on 11/12/19	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-87 Personal care services. (e) The primary care giver with the assistance of the case manager shall provide training to all substitute care givers and ensure that all services and interventions indicated in the expanded ARCH resident's care plan are provided to expanded ARCH residents by the substitute care giver. **FINDINGS** No documented case manager training for secondary care giver #2 and secondary care giver #4.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** New substitute care giver should be given training before they start working. "Reminder" was included on check list sheet IR 32 and placed in front of chart	11/12/19

ISLAND CARE MANAGEMENT

CAREGIVER'S SKILLS AND COMPETENCY CHECKLIST

Name: RUFO, ESTELLA	☐ CHO	☒ SCG
Date of Initial: 11-12-19		

Skills	Satisfactory	Unsatisfactory	Comments
1) Sponge (Bed) Bath, Tub Bath or Shower	☒	☐	
2) Shampoo (Bed), Sink or Tub	☒	☐	
3) Nail Care (Trimming & Filing)	☒	☐	
4) Skin Care	☒	☐	
5) Back Rub	☒	☐	
6) Oral Hygiene	☒	☐	
7) Transfer Techniques	☒	☐	
8) Range of Motion Exercises (ROM)	☒	☐	
9) Positioning	☒	☐	
10) Assisting with Toileting	☒	☐	
11) Temperature (Taking & Recording)	☒	☐	
12) Respiration (Taking & Recording)	☒	☐	
13) Pulse (Taking & Recording)	☒	☐	
14) Blood Pressure (Taking & Recording)	☒	☐	
15) Assisting with Diapering	☒	☐	
16) Assisting with Dressing / Undressing	☒	☐	
17) Universal Precaution	☒	☐	
18) Emergency Procedures	☒	☐	
19) Sharps Training	☐	☐	

RN Observations/Comments:

Authorized Registered Nurse Statement of Acknowledgement:
I certify that authorized caregiver has met the instruction requirements and has demonstrated the Skills and Competency Checklist.

Date	RN Signature	Date	Caregiver Signature
11/12/19	Elsa P. Talavera RN /Elsa P. Talavera RN	11/12/19	Estella Rufo

ISLAND CARE MANAGEMENT
P.O. BOX 893182
MILILANI TOWN, HI 96786
CELL: 808-358-8984
TEL: 808-536-7100 FAX: 808-536-7200

ISLAND CARE MANAGEMENT

CAREGIVER'S SKILLS AND COMPETENCY CHECKLIST

Name: BALISACAN, SONIA	☐ CHO	☒ SCG
Date of Initial: 11-12-19		

Skills	Satisfactory	Unsatisfactory	Comments
1) Sponge (Bed) Bath, Tub Bath or Shower	☒	☐	
2) Shampoo (Bed), Sink or Tub	☒	☐	
3) Nail Care (Trimming & Filing)	☒	☐	
4) Skin Care	☒	☐	
5) Back Rub	☒	☐	
6) Oral Hygiene	☒	☐	
7) Transfer Techniques	☒	☐	
8) Range of Motion Exercises (ROM)	☒	☐	
9) Positioning	☒	☐	
10) Assisting with Toileting	☒	☐	
11) Temperature (Taking & Recording)	☒	☐	
12) Respiration (Taking & Recording)	☒	☐	
13) Pulse (Taking & Recording)	☒	☐	
14) Blood Pressure (Taking & Recording)	☒	☐	
15) Assisting with Diapering	☒	☐	
16) Assisting with Dressing / Undressing	☒	☐	
17) Universal Precaution	☒	☐	
18) Emergency Procedures	☒	☐	
19) Sharps Training	☐	☐	

RN Observations/Comments:

Authorized Registered Nurse Statement of Acknowledgement:
I certify that authorized caregiver has met the instruction requirements and has demonstrated the Skills and Competency Checklist.

Date	RN Signature	Date	Caregiver Signature
11/12/19	Elsa P. Talavera RN /Elsa P. Talavera RN/	11/12/19	/Balisacan/

ISLAND CARE MANAGEMENT
P.O. BOX 893182
MILILANI TOWN, HI 96786
CELL: 808-358-8964
TEL: 808-536-7100 FAX: 808-536-7200

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-88 Case management qualifications and services. (c)(3) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall: Review the care plan monthly, or sooner as appropriate; **FINDINGS** No documentation that case manager met with resident #1 for the month of October 2019.	**PART 1** **Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.**	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-88 Case management qualifications and services. (c)(3) Case management services for each expanded ARCH resident shall be chosen by the resident, resident's family or surrogate in collaboration with the primary care giver and physician or APRN. The case manager shall: Review the care plan monthly, or sooner as appropriate; **FINDINGS** No documentation that case manager met with resident #1 for the month of October 2019.	**PART 2** **FUTURE PLAN** **USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?** CM should review care Plan in timely manner before they go on vacation Will review q month and "Reminder" was also included on Adm. Check list (ARCH IR 22) and placed in front of chart.	11/22/19

Licensee's/Administrator's Signature: _____

Print Name: Mary Ann Mc Murray

Date: 11/25/19